**Therapeutic Behavioral Services Accountability Structure**
**Report to the Department of Mental Health**

**Purpose:** The goal of the Therapeutic Behavioral Services (TBS) Accountability Structure is to identify and develop a statewide practice and performance improvement structure. This structure will include outcome and utilization measures and a continuous quality improvement process that will allow the California State Department of Mental Health (CDMH) to effectively ensure that TBS are accessible, effective, and sustained for the Emily Q class members as outlined in the Court-approved TBS Plan.

The accountability structure, to be implemented by CDMH, will be accomplished through annual reports submitted by the county Mental Health Plans (MHPs). This new report utilizes a quality improvement process based on principles and accountability activities that focus on practice and service coordination, rather than compliance and disallowances. The report is designed to increase Emily Q class access to appropriate TBS services. This approach requires an interagency review of relevant data in response to four questions, utilizing a standard report format.

—Nine Point Plan, Appendix C

**Directions: Please provide a brief summary of the answers to the following four questions as discussed in your local learning conversation (both Level I and Level II counties). Per the Nine Point Plan, it is the Mental Health Director's responsibility to submit the completed form. Please save this form to your computer then submit, along with a list of attendees, to TBS@dmh.ca.gov.**

**County MHP** Alameda
**Date of Meeting:**
September 28, 2010
**MHP Contact (name, phone, e-mail):**
Sara Wood-Kraft, Ph.D., 510-667-7545, SWoodKraft@acbhcs.org
**Was this a Stakeholder or Decision-Maker meeting?** Stakeholder
**Note: List of Attendees is attached**

**1. Are the children and youth in the county who are Emily Q class members and who would benefit from TBS, getting TBS?**

We had 13 consumers and family members at this meeting. Their response to this question was loud. Because they felt that TBS was so valuable to their families, they agreed that TBS felt like "a well-kept secret." They felt that, had TBS been available to their families earlier, the lives of their children and the families they lived in might have gone differently. The first barrier they identified was age. Family members felt that TBS should be more widely publicized among those child-care centers and agencies that provide services to very young children, because early intervention would allow "great progress."

Additionally, the group discussed services to Transitional Age Youth and the challenges involved in providing services to those youth who must sign their own consents for treatment. Regarding gender, the group discussed the idea that many TBS-referred youth are identified at school as well as at home, and that more boys than girls are likely to be school-identified for acting-out behaviors. They discussed the need for more male TBS coaches, and the fact that most caregivers are females and many of the boys receiving TBS do not have sufficient positive male role models in their lives. One parent noted

that youth may display different behaviors with different genders, making it important to identify specific gender-related needs that a particular coach might be able to meet.

Discussing language and culture as possible barriers, the group noted that TBS coaches whose language matches the families may learn much more about the needs of the child, especially if serving a child whose limited English language skills prevent them from speaking much at school.

Other agency-related barriers noted by the group included: agency turnover (mental health providers need to be constantly retrained to make referrals) and lack of agency coordination when youth are hospitalized or incarcerated and TBS services are 'locked out.' Other administrative barriers noted by the providers included the issues arising from billing across placement changes. If DSS workers change or if SSI becomes available, the youth's Medi-Cal may change from one county to another.

In general, the group felt that, despite the demands of TBS expansion, there has not been a lack of providers. The coaches hired have been generally good fits for families/caregivers, even with particular cultural or linguistic demands. An example of this is that one agency, faced with the request for an ASL-signing coach for a deaf family, was able to recruit such a coach and to provide service to the youth in an appropriate manner.

**2. Are the children and youth who get TBS experiencing the intended benefits?**

This group's answer is a resounding "yes." Families and caregivers were able to list several specific benefits gained from TBS; the youth present (ranging from age 5 to age 14) were also able to list benefits. The families' and caregivers' list included: behavioral interventions such as "One, Two, Three Magic!" and "Stoplight" techniques; the ability of TBS coaches to come to the home or school and see the 'real' situation; the consistency of service; and the helpfulness of the treatment plans' goals and objectives. The youth present listed behavior-change specifics such as "changing the channels," breathing techniques, tapping for self-soothing, and enhanced abilities to follow directions. In addition, when offered the list of specific benefits suggested in the Local Meeting Facilitation Guide, both parents and children insisted that the meeting recorder write, "All of 'em!!!" "All of 'em" includes: improved self-management, improved coping ability, reduced stress, reduced need for placement, ability to step down from high-level placement, improved interpersonal skills, improved communication, improved relationships at home, school success, and reduced delinquency.

Providers present agreed that once the referral is completed and the family is engaged, the benefits are quickly apparent. Once parents understand the process and believe it will be useful to them, they participate actively and express a wish for more. In this meeting the identified issues concerned making TBS more widely available sooner. No one questioned the usefulness of service after the family is engaged. NOTE: The group recognized that they did represent the families who have become engaged. It was suggested that we might survey families who discontinued TBS to discover whether they had or had not experienced benefits.

**3. What alternatives to TBS are being provided in the county?**

Alameda County is not offering alternatives to TBS that are intensive, focused, and sustained at a one-to-one level that is in addition to therapy. Services being offered are not one-to-one (they are family focused, for instance) or they do not have individual measurable goals and objectives with a functional analysis of the goals of challenging behaviors.

**4. What can be done to improve the use of TBS and/or alternative behavioral support services in the county?**

This question was posed to the group as: What Would Make TBS Easier to Get? The answers generally took the form of suggestions for outreach, listed below:

- Put more information about TBS on the Internet
- Shift the language about TBS from shame-based (problem) to resource-based (help, coaching).
- Inform therapists and schools about TBS.
- Make easily readable brochures to be available at: Welfare Office, Children's Hospital, Schools and Therapists' offices, Community service agencies (Parks and Rec, Libraries, Boys' and Girls' Clubs)
- Make brochures commonly available at hospital discharge points (Alameda County has been working on this, which is a State requirement).

Additionally, Providers suggested that there should be more training in graduate school about behavioral interventions such as TBS, including documentation training to prepare graduates to handle Medi-Cal and TBS paperwork. The suggestion was that the culture of therapy does not always include education and training about measurable behavior change; training more students in these methods would allow for more acceptance and understanding of the usefulness of such programs.

**Additional Comments:**

This Stakeholder meeting focused on feedback from children and their families. It was intentionally small so that youth and their caregivers would be comfortable speaking in an informal environment.

Our second Stakeholder meeting, scheduled for November 9, will include additional representatives from the court and probation, education, child welfare, child attorneys, and mental health providers.